



Annual Knowledge, Practice and Coverage Survey Report

Emergency Assistance to Conflicted Populations

Democratic Republic of Congo

July 2015

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I. Introduction

I.1. Project background

Mercy Corps in Democratic Republic of the Congo (DRC) conducted a Knowledge, Practice and Coverage (KPC) Survey in July 2015 to measure access to basic needs in water as well as sanitation and hygiene habits of WaSH beneficiaries in camps in Masisi, Rutshuru and Goma as well as villages in Nyiragongo territory. The objective of the survey was to provide end line information on the recently completed EACAP-IV project on sources of water as well as access and use indicators related to water, sanitation and hygiene to assess the baseline situation for the fourth iteration of the OFDA-funded year-long project, Emergency Assistance to Conflict-Affected Populations (EACAP-IV). The survey included IDP households both in the camps in the Mweso, Birambizo and Goma areas where Mercy Corps has been conducting WaSH activities.

The populations within these IDP camps have experienced periodic changes in security and large waves of displacement, resulting in population increases within camps and thus lack of access to basic needs such as water, sanitation and hygiene needs, as well as relatively instable livelihoods. Due to conflict, WaSH infrastructure in many camps has been damaged and needs rehabilitation, and newly arrived IDPs are accelerating the already growing needs for appropriate and sufficient provision of potable water, clean latrines, shower stalls and personal hygiene facilities.

The EACAP-IV project provided water, sanitation and hygiene activities and access to livelihood activities for people in North Kivu. Drawing from the previous three EACAP projects and in line with Millennium Development Goal 7 which seeks to halve by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation, Mercy Corps' EACAP-IV project is providing emergency WaSH support to 20 IDP camps and their surrounding areas in North Kivu in accordance with North Kivu WaSH Cluster standards while building local WaSH capacity in support of self-sufficiency strategies. By the end of this project, IDPs will have access to sufficient potable water and hygienic sanitation facilities and will be practicing sound hygiene to ensure their health and dignity in IDP camps and upon their return.

Mercy Corps will continue to respond to urgent humanitarian needs, while adapting our emergency WASH strategies with a vision toward supporting communities to transition from humanitarian relief to self-sufficiency and longer-term recovery and development. When Mercy Corps' evaluations show that camps are able to manage WASH services on their own, Mercy Corps will implement exit strategies to hand the WASH systems and infrastructure over to the camp management committees, which have been trained by Mercy Corps.

A qualitative evaluation of the EACAP-II project found that an important strategy to help IDP populations to achieve sustainable outcomes was to combine traditional emergency interventions with activities that promote resilience, such as training on IGAs. By combining basic need provision in the WaSH sector with cross-cutting and long-term livelihood strategies such as IGA and camp management training, EACAP-III sought to reinforce transition among camp populations from dependence on emergency actors toward self-efficient and resilient structures already existing in the camps. As this component did not have any impact-level indicators, it was not rigorously measured as a part of this KPC study, and should be evaluated further using qualitative studies.

I.2. Survey objectives

In order to provide a point of comparison to measure the success of these activities as well as the crosscutting themes within the project, the objectives of the baseline study were:

- 1) To collect baseline information (for EACAP V) to report against indicators within the project logical framework;
- 2) To assess the extent to which Mercy Corps is providing basic WaSH needs to the IDP populations in Mweso, Birambizo and Goma areas covered by previous EACAP-IV grant;
- 3) To assess the situation in key WaSH indicators in new areas that will be covered by EACAP-V;
- 4) To serve as an initial formative research to identify key determinants affecting key behaviors and knowledge among IDP populations;
- 5) To assess the effectiveness of basic hygiene sensitization and BCC strategies and provide direction for future formative research.

II. Methodology

II.1. Sampling

The sampling strategy for the final evaluation was designed to measure any change in the Percent of target population demonstrating good hand-washing practices, using the formula below:

$$n = D[(Z_{\alpha} + Z_{\beta})^2 \times (sd_1^2 + sd_2^2)/(X_2 - X_1)^2]$$

KEY:

- n = required minimum sample size per survey round or comparison group
- D = design effect
- X1 = the estimated level of an indicator at the time of the first survey
- X2 = the expected level of the indicator either at some future date or for the project area such that the quantity (X2 - X1) is the size of the magnitude of change or comparison-group differences it is desired to be able to detect
- sd1 & sd2 = expected standard deviations for the indicators for the respective survey rounds or comparison groups being compared
- Z_{α} = the z-score corresponding to the degree of confidence with which it is desired to be able to conclude that an observed change of size (X2 - X1) would not have occurred by chance (statistical significance), and
- Z_{β} = the z-score corresponding to the degree of confidence with which it is desired to be certain of detecting a change of size (X2 - X1) if one actually occurred (statistical power).

Therefore the minimum required sample size to measure this change would be approximately 544 households. Since the baseline survey visited 441 households, statistically valid comparisons of these indicators can be made.

II.2. Survey instrument

The survey instrument was essentially drawn from the baseline questionnaire, covering specific concerns on access to water, sanitation and hygiene facilities, including hygiene practices. This instrument was pre-tested with the enumerators in Goma and Mweso. Modification of the instruments was done based on the feedback. Issues on data gathering faced by the pre-testing team were discussed and addressed accordingly

The final evaluation questionnaire was organized as follows:

- Introduction/consent
- A. Demographics
- B. Water
- C. Sanitation
- D. Hygiene
- E. Knowledge and Practice

II.3. Enumerators training

All data was collected by locally-hired staff trained as enumerators and supervised by MC staff. Two teams of ten and twelve enumerators carried out the household data collection from 18 June to 9 July. Twenty-two enumerators and two team leaders participated in a two-day training event held in Goma and Mweso. The training included survey objectives, interview techniques and pre-testing of the questionnaire.

II.4. iPod-based data collection

All household data was collected on iPods for digital data collection, as this survey was conducted using the iForm/iFormBuilder software. Digital data collection has been shown to reduce the time and burden of data collection, cleaning and analysis, as well as allowing for much richer data analysis, facilitating the combination of GPS data with survey data and permitting the team to analyze more precise geographical trends for complex indicators. Data was uploaded to a password-protected iFormBuilder online database at the end of each day and was subsequently examined to ensure quality. After the final day, data was cleaned and weighted for analysis through SPSS v13.0.

III. Evaluation findings

III.1. Demographics

Table 1 below presents basic respondent demographics. For the baseline survey, enumerators were more likely to have interviewed female household members (77.3%) with a mean age of 38 years, while in the final survey; we recorded 64.2% female household members. Note that the selection of the respondents per household was dependent on who was present during the interview.

The distribution of the respondents by age for the final survey, the youngest is 13 and the oldest is 84. The average age is 39.3, while it was 38 when we conducted the baseline. A majority of the respondents at this final survey (75%) falls under the age of 50. The age of the respondents was limited for household members to 12 years and above due to the nature of the questions. Younger community members may not fully understand the questions.

Table 1: Respondent demographics

| | | Baseline | Final |
|-------------------|--------|----------|-------|
| Sex | | % | |
| | Male | 22.7 | 35.8 |
| | Female | 77.3 | 64.2 |
| Mean age in years | | mean | |
| | Age | 38.0 | 39.3 |
| N | | 441 | 544 |

Contrary to the baseline survey, the vast majority of respondents consider farming to be their primary source of household income. There still a large number of unemployed people (23% against 31% at the baseline). Other income sources include small businesses (13%-21%), vendor/small trader (6%-10%).

Table 2: Primary occupation

| | Baseline | Final |
|----------------------------------|----------|-------|
| Primary occupation | % | |
| <i>Unemployed</i> | 31 | 23 |
| <i>Agriculture</i> | 26 | 49 |
| <i>Small business/day worker</i> | 21 | 13 |
| <i>Vendor/small trader</i> | 10 | 6 |
| <i>Teacher</i> | 3 | 1 |
| <i>Handcraft</i> | 1 | 4 |
| <i>State agent</i> | 1 | 0 |
| <i>Driver</i> | 1 | 0 |
| <i>NGO Employee</i> | 0 | 0 |
| <i>Motorcycle driver</i> | 0 | 1 |
| <i>Other</i> | 0 | 3 |
| Total number | 441 | 544 |

On average surveyed households were slightly smaller with an average of 5.2 household members compared to 6.0 members from the baseline. In addition, there were slightly more dependents with households having an average of 4.9 children under the age of 18 years.

Table 3: Household size

| | Baseline | Final |
|---|----------|-------|
| | Mean | |
| Household size | 6.0 | 5.2 |
| Mean number of children (under 5 years of age) | 4.2 | 4.9 |
| Total number of households surveyed | 441 | 544 |

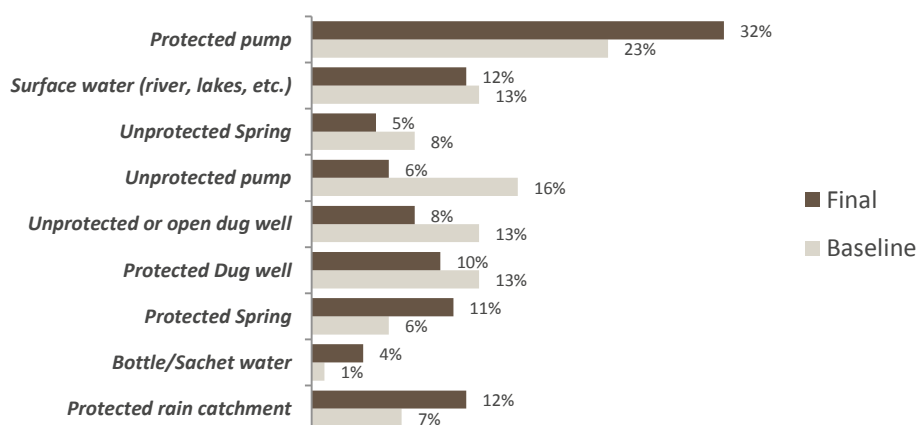
III.2. Household water supply and practices

Water sources

The section covers water sources, safe water chain, household water treatment and water point maintenance.

The result from this survey has shown that, at least 91.3% (it was 84.4 last year) collect drinking water from protected pumps and only a few section of the population takes from unprotected sources such as surface water (rivers, streams), meaning that water provision has diversified since last year, availability of clean water sources has drastically increased, water sources are more accessible.

Figure 1: Drinking Water Sources



Water for domestic use such as cooking, laundry and hygiene (cleaning, dishwashing, bathing) is taken similarly from same sources as indicated in the figure above. It has been observed that the number of people fetching water for domestic use from surface water and unprotected springs has decreased.

Water Collection, Containers and Water Treatment

Collecting water is a major household task in the rural locations irrespective of what distances are covered and the water point types. In general, the burden of collecting water is mostly with women, who make up more than half of the household members. Women and girls are traditionally responsible for collecting water and this has been shown during the 2 surveys.

Table 4: Water collection indicators

| | Baseline | Final |
|--|----------|-------|
| | Mean | |
| Water source within 30 minutes from the household | 90.0% | 91.8% |
| Time Spent for Collecting Water (in minutes) | 17.5 | 18.2 |
| Average time waiting in line for water collection (minutes) | 26.6 | 24.3 |
| Number of households surveyed | 441 | 544 |

As shown in the table above, the water points are closer to the surveyed household. They are within less than 30 minutes for a large part of the population (91.8% for the final survey, 90% for the baseline).

Distance is a major factor impacting the time commitment that respondents allot to collecting water from the water sources. Given that water is quite near to a majority of the respondents, they spend 18.2 minutes in collecting water (this was 17.5 during the baseline). The time spent for fetching water is calculated on the basis of both going to the water source and returning to the dwelling place.

Water Consumption, Maintenance of the Water Point and Containers

For most users, they use the same containers to both collect and store water. Almost the same number 75% of the population uses jerry can (gallon-type) as both a collection and storage container for drinking water. Over the life of the EACAP-IV project, the average water usage among the IDP population in the covered camps has increased from 10.7 to 11.4 liters per person per day, but this stills low compared to internationally accepted emergency Sphere standards of 15 liters per person per day. To confirm, in terms of water availability, the target camps exceeded Sphere standards, but households still face challenges related to adequate water storage as well as in hygiene awareness. Another factor that may have contributed to this result was that the survey was conducted during harvest time, when households had less time for water gathering.

For those treating their water (Fig.19), chlorination is the most common method, scoring 88%. There are small portions of the population using traditional treatment methods such as solar disinfection (7%), boiling (3%) and cloth filtration (2%). Note that the percentage for the water treatment methods does not represent the whole population but the practice of the 12% that say they treat their water.

Table 5: Water consumption indicators

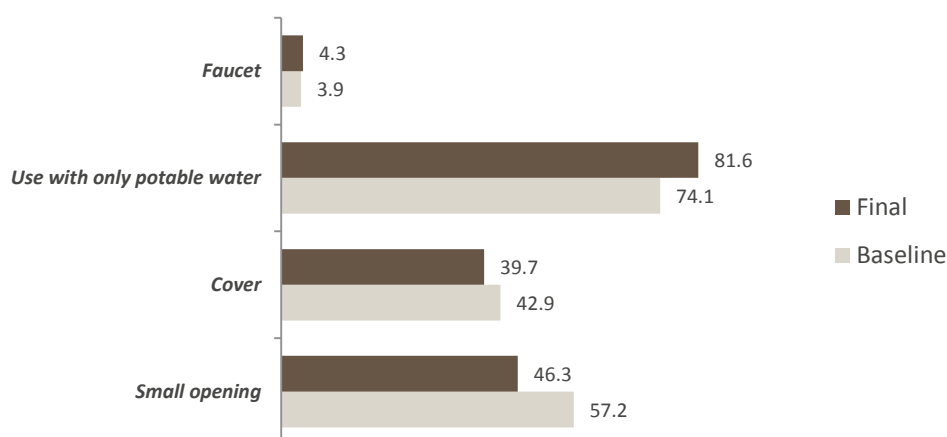
| | Baseline | Final |
|---|----------|-------|
| | Mean | |
| Number of 20-L water containers used per day | 3.0 | 3.2 |
| Liters per person per day | 10.7 | 11.4 |

| | | |
|-----------------|-----|-----|
| Number surveyed | 441 | 544 |
|-----------------|-----|-----|

Regarding water treatment, at the household level, members do not always clean and cover water containers. In 2014, only 40% of the households surveyed use clean water containers while 56% covers their water containers using their own methods. The survey observed that correct home water treatment strategies practiced within the camps include boiling to a rolling boil, chlorine packet use, and using Aquatabs. In 2014, it was found that only 5.2% of households perform correct home treatment, and now the percentage has reduced to 4.6%, but this is in part due to the fact that the project has provided clean water at the tap.

Storage of water in safe storage containers consists of using a container with an opening of less than 10 centimeters solely destined for potable water storage, and assuring that the container has both a faucet and a cover. As faucets are not the norm in DRC, our analysis considers a modified definition (with all other factors other than the faucet). Last year, 28.8% of the population used the modified definition of a safe storage container, whereas this year 40.1% of households use the modified safe storage container. The figure below shows the repartition of water storage techniques during the baseline and the final evaluation; although households are less often using containers with small openings and covers, there is an increase in households demonstrating all of these best practices together.

Figure 2: Water storage techniques



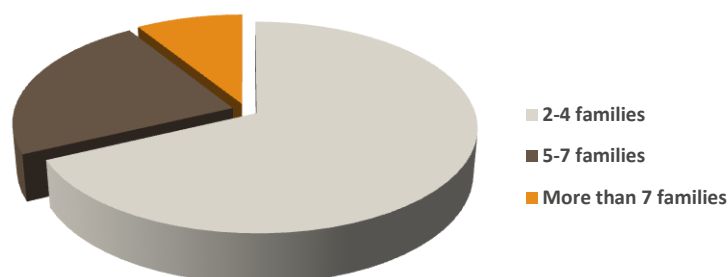
III.3. Sanitation practices

The section discusses sanitation practices, which include latrine use, type of latrine, reasons for having latrines, baby feces disposal, and solid waste management.

The results from this evaluation have shown that access to sanitation facilities is still high for the entire surveyed area. It was found that 98.2% of the interviewed households take advantage of community or private latrine access (compared to 97.8% during the baseline). The surveyors asked whether latrine separated by sex were being respected, and only 28.6% of the population agreed that men were using only men's latrines and women were only using women's latrines (this percentage was slightly lower than last year's 31.1%).

The figure below indicates that for the households having latrines, more than half (52%) of those facilities was constructed by the families themselves. This is closely followed by the latrines constructed by NGOs (44%). Only 4% of these latrines were constructed by local authorities or government. A majority of these latrines are shared with other families. The figure below reveals that 68% shares with 2-4 families, 9% share with 5-7 families, and 23% share with more than 7 families.

Figure 3: Number of families sharing a latrine



The table below represents information on the proportion of latrines with evidence of use. We found that as for the baseline, the majority of latrines had protected entries (82.2% against 80.6% during the baseline).

Table 6: Proportion of latrines with evidence of use (in %)

| | Baseline | Final |
|---|----------|-------|
| Protected entry | 80.6 | 82.2 |
| The area smells | 79.4 | 77.8 |
| Path to latrine has been walked on | 84.4 | 86.8 |
| Detected feces in pit using flashlight | 70.1 | 71.3 |
| Slab is wet | 72.9 | 71.7 |
| Used toilet paper or plant leaves | 20.0 | 23.4 |
| Total Number of Households | 441 | 544 |

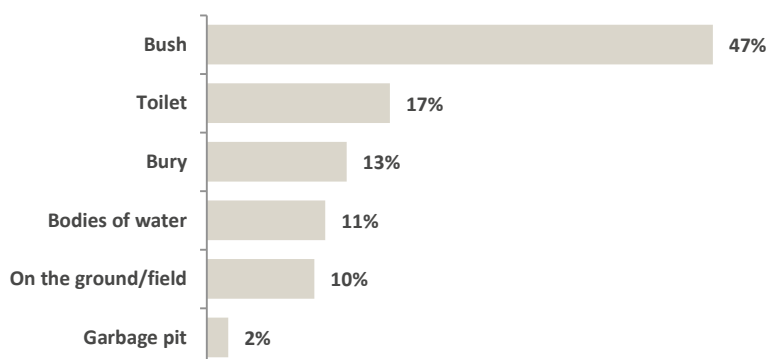
Asking surveyed community members why they use a latrine, the results have shown that the most common and dominant reason why people have latrines is that it prevents from illness. Comparing to the baseline, it rose that there has been a marked increase in community members recognition above all that latrine use prevents illness. Only 3% of interviewed households revealed that having a latrine is not a priority (against 5% during the baseline), some say there is a lot of land on which to defecate (2%), and defecation is not an issue (2%) and no space for constructing latrine (2%).

Table 7: Percentage of population citing reasons for and against latrine use

| | Baseline | Final |
|---|----------|-------|
| Prevent illness | 86.8 | 88.2 |
| Privacy | 16.7 | 13.8 |
| Avoid oral-fecal contamination | 14.2 | 23.4 |
| Sensitization from community health worker | 10.9 | 13.3 |
| Comfort | 5.6 | 4.2 |
| Total number surveyed | 441 | 544 |

The figure below shows that baby feces are usually thrown in the bushes (47%). Other practices of disposing infants' feces include throwing into the toilet (17%), burying (13%), throwing into bodies of water (11%), throwing on the ground/field (10%) and into the garbage pit (2%). Thus, 68% are still using unsafe practices, which pose public health risks to the rest of the population. Only 32% of these practices are considered safe.

Figure 4: Baby's Feces Disposal



III.4. Hygiene

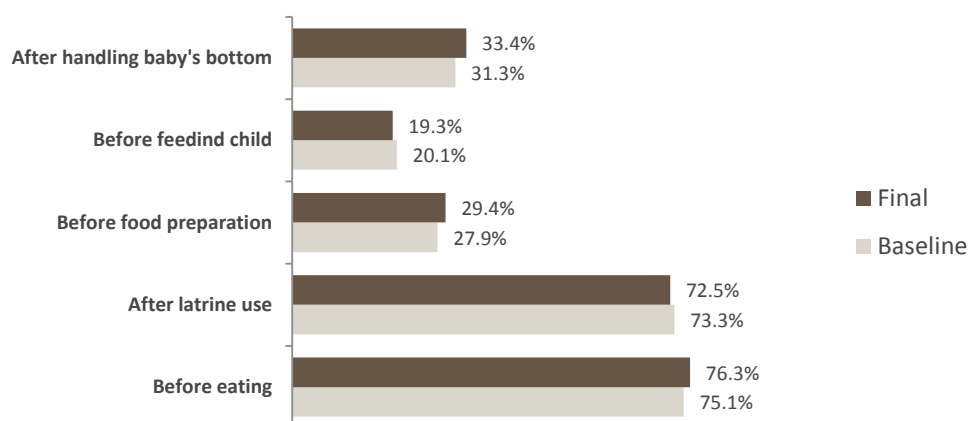
Hand washing

The section presents and discusses practices on hand washing, hand washing agents used, reasons for not washing hands with soap and hand washing facilities available at home.

The final evaluation has shown that only 13.2% of the population (this was 11.5% during the baseline) practice correct hand-washing practices, meaning that when asked to cite the 5 critical moments for hand-washing as well as to demonstrate the 5 steps of appropriate hand-washing, they could respond with at least 8 out of 10 correct responses.

The figure below shows the key times people usually wash their hands. The most common time mentioned by 76.3% of the respondents is washing hand before eating. This is followed by hand washing after latrine use (72.5-73.3%) and before food preparation (29.4%-27.9%).

Figure 5: Key times people usually wash their hands



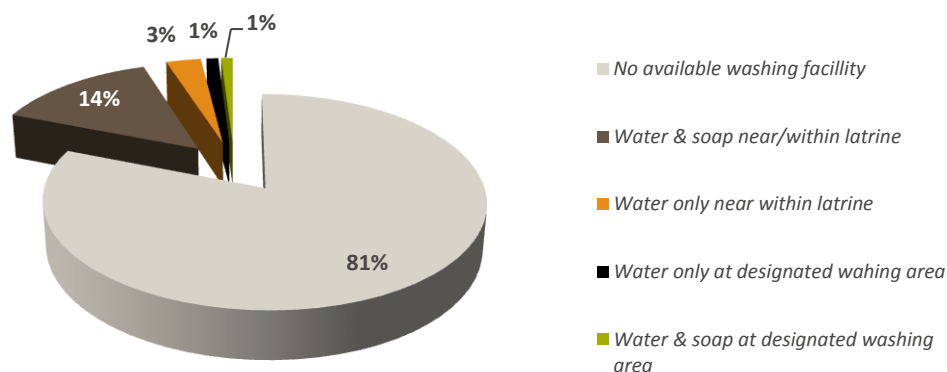
The analysis has shown that there are four main groups of agents used by respondents in washing their hands. This is illustrated in the table below where for the 2 surveys; there is a substantial number of people who use water only for hand washing (62.5 and 60.2%). Water or ash dominates as the second agent of hand washing, with a score of more than 30% for the two periods, while others OMO detergent (respectively 14.1% and 16.2%) and sand/mud (0.1% and 0.3%).

Table 8: Agents Used in Hand Washing (in %)

| | Baseline | Final |
|----------------------|----------|-------|
| Water only | 62.5 | 60.2 |
| Water or ash | 32.5 | 35.7 |
| Ash | 6.8 | 7.4 |
| OMO detergent | 14.1 | 16.2 |
| Soap | 10.4 | 12.2 |
| Sand/mud | 0.1 | 0.3 |
| Number | 441 | 544 |

The team looked out for the availability of hand washing facilities. Most of the households as observed have no washing facilities (81%). Only very few were observed to have washing facilities. Only 14% of the respondents were found to have water (and sometimes soap) near/within their latrines while the same percentage had water and soap in designated washing areas (no latrine) and another 3% in households had water only at designated area.

Figure 6: availability of hand washing facilities



Food hygiene

Regarding food hygiene of the household, series of questions were asked to respondents, among which they were called to describe if the last time they prepared food, they used clean utensils, washed fruits and vegetables, washed their hands before preparing, cooked or re-heated food before eating, and if they used expired food to eat. The analysis has shown that compared to the baseline level, food hygiene behaviors have not drastically improved, as shown in the table below.

Table 9: Food hygiene practices during the preparation of the last meal (% of households)

| | Baseline | Final |
|--|----------|-------|
|--|----------|-------|

| | | |
|---------------------------------|------|------|
| Use of clean utensils | 96.2 | 98.4 |
| Wash fruits and vegetables | 87.8 | 89.7 |
| Wash hands before preparing | 88.5 | 91.4 |
| Cook or re-heat food | 87.3 | 89.8 |
| Use of spoiled or expired foods | 27.2 | 41.6 |
| Number | 441 | 544 |

We finally asked participants where they stored food last time they had uneaten leftovers, and then asked if we could see where those leftovers are stored. Once again, it was shown that food safety practices have not improved. Results are indicated in the table below.

Table 10: Actual location of foods (per % of households)

| | Baseline | Final |
|--|----------|-------|
| <i>Cited location of food stored</i> | | |
| On the floor | 57.4 | 66.2 |
| Using stones and shelves | 0.0 | 0.0 |
| On a wooden shelf | 15.6 | 28.3 |
| On the table | 3.9 | 3.6 |
| In a cupboard | 0.3 | 0.8 |
| No leftovers available to store | 14.7 | 8.2 |
| <i>Actual status of food stored</i> | | |
| On the floor | 69.2 | 71.3 |
| Easily accessed by animals | 23.1 | 18.7 |
| Protected from sunlight | 58.1 | 56.4 |
| Well covered | 78.7 | 82.7 |
| Flies or another insects were found in/around the food | 25.1 | 13.4 |
| N | 441 | 544 |

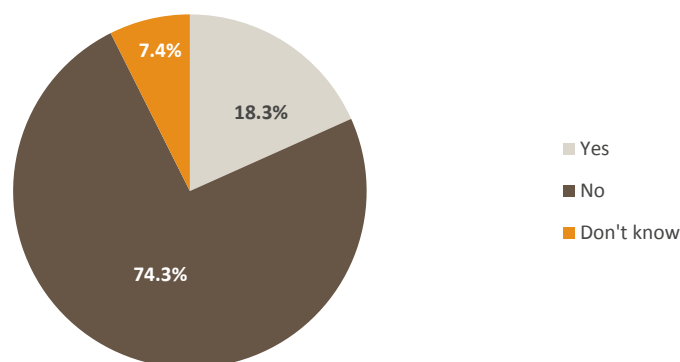
III.5. Diarrhea morbidity

The section is about the prevalence of diarrheal and malarial diseases including peoples' belief of the causes, management and prevention of these diseases.

Diarrhea morbidity, management & prevention

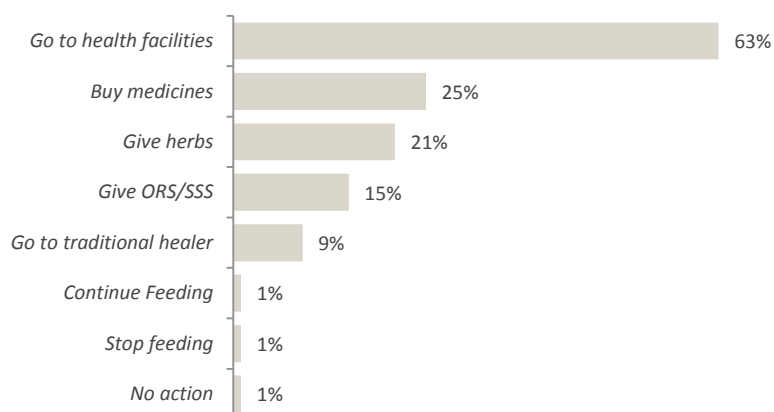
The figure below indicates that there were 173 cases of diarrhea in the last 2 weeks before the survey affecting 18.3% of the population. The population most highly impacted was children 0-5 years of age accounting for almost half of the cases (47.4%).

Figure 7: Diarrheal cases



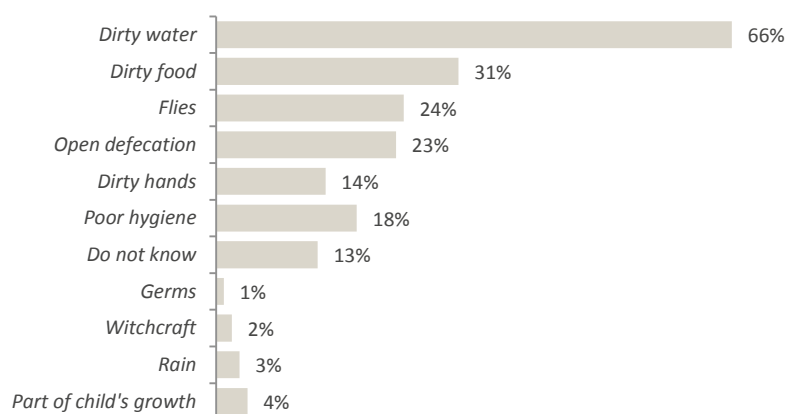
The figure below specifies how families manage diarrhea. A majority of the population brings their family members with diarrhea to health facilities (63%) while substantial members of the population buy medicines (25%), give herbs (21%), ORS/SSS (15%), 9% go to traditional healers.

Figure 8: Diarrhea management



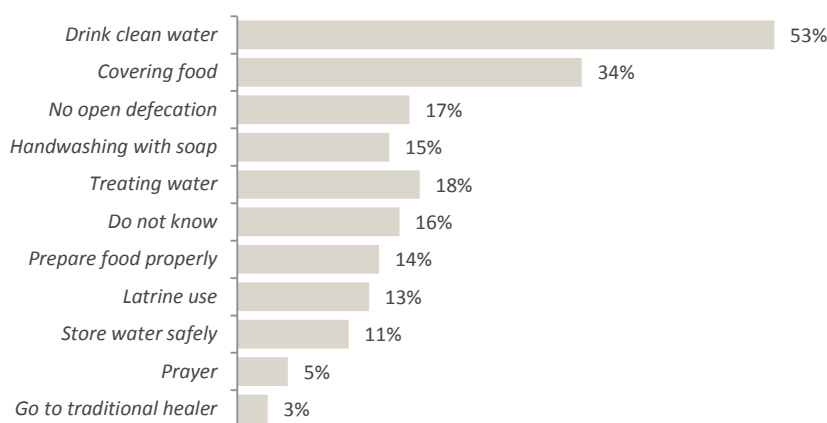
The most popular belief of the cause of diarrhea (the figure below) is the consumption of dirty or contaminated water (66%). Others believe that dirty food (31%), flies (24%) and open defecation (23%) can cause diarrhea. There are also those who believe that dirty hands (14%) and poor hygiene (18%) result in diarrhea. At least 13% has no idea what causes diarrhea. There is a 2% belief that diarrhea is caused by witchcraft and another 3% thinks it is caused by the rain.

Figure 9: Causes of diarrhea



Finally, for diarrhea prevention, the figure below discloses that a bit more than half of the population believes that diarrhea can be prevented through drinking clean water (53%). The covering of food can also prevent diarrhea (34%) while others (17%) believe that not defecating in the open prevents such disease. Though not very popular, respondents also added that hand washing with soap (15%), treating water (18%), proper food preparation (14%), latrine use (13%) and storing water safely (11%) can also prevent diarrhea. However, 16% of the respondents say they do not know how to prevent diarrhea, which is not surprising as 13% does not know the cause (figure above). Though not popular opinions, there are beliefs that prayers (5%) and consulting traditional healers (3%) can prevent diarrhea too.

Figure 10: Diarrhea prevention



Diarrheal cases in relation to water, sanitation & handwashing

The cases of diarrhea also correlate with the kind of water points people use for drinking. The figure below shows the differences in diarrhea prevalence between improved water facilities and non-improved water facilities. The diarrheal cases are more than half lower in improved water facilities (14%) compared to the non-improved water facilities (42%). These figures were generated by cross-tabulating the number of diarrheal cases and the water points.

The number of diarrheal cases between families who possess latrines and those do not is marginal when we compare access to sanitation facilities. It was found out that 38% of families having latrines had diarrheal cases while 40% of families having no latrines reported cases of diarrhea. In this particular instance, the cause of diarrhea cannot be attributed to latrine facilities alone. Rather there is a need to consider other factors such as water sources, peoples’ practice on safe water chain and other hygiene practices.

III.6. Health, knowledge and perception indicators

Questions on knowledge about diarrhea, cholera, and malaria were posed to the survey participants, and they were given their opinions about the causes, prevention, and treatment of these diseases in order to help re-focus future project behavior change campaigns. It was found that compared to the 21.2% during

the baseline, actually 33.6% of the population slept under a mosquito net the night before the interview. When asked how people fall ill from diarrhea or malaria, the surveyed mentioned many different sources of these illnesses, as presented in the table below.

Table 11: Proportion of the population reporting perceived causes of diarrhea and malaria

| | Baseline | Final |
|-------------------------------------|----------|-------|
| <i>How to catch diarrhea</i> | | |
| Dirtiness | 62.7 | 64.6 |
| Contaminated food | 22.6 | 36.4 |
| Dirty hands | 48.1 | 56.3 |
| Flies | 16.3 | 18.6 |
| Dirty water | 26.2 | 41.8 |
| Sorcery | 0.7 | 0.2 |
| Intestinal worms | 0.0 | 0.2 |
| I don't know | 10.4 | 3.6 |
| <i>How to catch malaria</i> | | |
| Mosquitos | 75.9 | 81.6 |
| Hot temperatures outside | 10.2 | 8.7 |
| Drinking dirty water | 10.2 | 13.4 |
| Coldness/climate change | 0.0 | 2.7 |
| Sorcery | 0.1 | 0.0 |
| I don't know | 14.5 | 10.3 |
| Total number surveyed | 441 | 544 |

IV. Conclusion

Regarding the results from the final evaluation that we conducted, EACAP-VI project achieved, overall, positive change in terms of access to water, access to clean and functional sanitation facilities and hygiene practices in all target areas of implementation.

It was observed also that some indicators remain low, in particular in the hygiene sub-sector owing to harsh geographical conditions in North Kivu, cholera epidemics and chronic displacements. In fact, because of frequent population movements, among households surveyed at this endline, many are likely new arrivals to the target camps and likely did not benefit from hygiene awareness-raising offered by the EACAP IV program. However the major improvements as demonstrated in the report show that the proposed integrated WASH approach is having effects on the target population.

Mercy Corps proposes to build on these achievements over the course of EACAP-V in order to maintain and improve the WASH situation; while working towards sustainable impact in the camps as well as their host communities. In addition, Mercy Corps will take lessons learned from this evaluation and apply them at scale within the new project to ensure even more effective programming. For example, this report suggests that current sensitization efforts for improved knowledge and attitudes about hygiene practices have had little effect on displaced populations, so other strategies such as Community-Led Total Sanitation and “Designing for Behavior Change” methodologies should be tested in the new program iterations. Contrarily, clean water access has largely increased with drastically improved times for access, open defecation has decreased, and diarrhea rates have decreased, so Mercy Corps will continue scaling these successful evidence-based activities to continue to reach more populations.

ABOUT MERCY CORPS

Mercy Corps is a leading global humanitarian agency saving and improving lives in the world's toughest places. With a network of experienced professionals in more than 40 countries, we partner with local communities to put bold ideas into action to help people recover, overcome hardship and build better lives. Now, and for the future.



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